Connecticut Society of Eye Physicians

Annual Education Program

Date of Event ___________

Physician Registration Credit Card Payment Form

Fax to 860-567-3591 or Email debbieosborn36@yahoo.com

______Visa ______ Mastercard ______ American Express

____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /____ /

(16 digit card number)

____ /____ /____

(Expiration date)

____ /____ /____

*3 digit # that appears on the back of the Visa/Mastercard

____ /____ /____ /____

*4 digit # that appears on the front of the American Express

Please print M.D. names of who payment is being made

____ ____

____ ____

____ ____

____ ____

$ ___________ Total amount charged

____ ____

(Card holder's name) (Card holder's signature)

____ ____

(Card holder's address - where statement is mailed) (Group Practice name)

____ 5 digit Zip code (*required) ___________

(City - State)

______________________ Email address

CSEP, 26 Sally Burr Road • P.O. Box 854 • Litchfield, CT 06759

Please fill out completely! *These numbers are required